5 Year Anniversary Retreat

Executive Summary

The NHAAP at 5 Years

June 1996 marked the fifth anniversary of the National Heart Attack Alert Program (NHAAP) and, to commemorate the event, a special retreat was held in Ellicott City, Maryland. The NHAAP was established by the National Heart, Lung, and Blood Institute (NHLBI) in June 1991 in response to scientific research that indicates that prompt medical treatment—notably, thrombolytic therapy—significantly improves survival rates for patients with acute myocardial infarction (AMI) and improves the quality of life for the patients and those around them. The overall mission of the NHAAP is to reduce morbidity and mortality from AMI, including sudden cardiac death, by reducing delay from the time of recognition of symptoms to treatment in the emergency department (ED).

The NHAAP consists of representatives of 40 organizations that include not-for-profit, professional, voluntary, and Government organizations that are national in scope, have a membership network, and share the NHAAP's goal of reducing morbidity and mortality rates from AMI and sudden cardiac death.

The objectives of the retreat were to review the accomplishments of the NHAAP's first 5 years, determine key areas of focus for the next 5 years, consider the structure and processes of the Coordinating Committee and subcommittees, and examine the role of the member organizations.

Progress Review

The Coordinating Committee members pointed to several examples of program success during its first 5 years. These included:

- A reduction in time to treatment in the ED (a major program focus during the NHAAP's first 5 years);
- Publication of peer-reviewed articles on patient/bystander, prehospital, and ED delays;
- Dissemination of the NHAAP message about the critical importance of early recognition and treatment of individuals with AMI (ideally within the first hour after symptom onset) through articles in professional publications and at symposia;

- A possible NHAAP role in increasing awareness about the importance of 9-1-1 coverage throughout the Nation as well as the number of ambulances with defibrillators as part of their standard equipment;
- The raising of relevant questions concerning managed care and access to care for individuals with symptoms and signs of an AMI;
- The recommendation that the NHLBI fund a research program on community interventions to reduce delay time associated with recognition of and response to individuals with a potential AMI, which is currently under way (as the Rapid Early Action for Coronary Treatment [REACT] trial).

Identifying Special Areas of Focus for the Next 5 Years

The Coordinating Committee members agreed that although the NHAAP had demonstrated success in meeting some of its goals, the mission is as yet incomplete and there is much work to be done. The NHAAP Coordinating Committee identified the following areas of focus for program activities for the next 5 years.

- *Evidence-based evaluation of diagnostic technologies, strategies, and protocols for identifying acute cardiac ischemia (ACI), including non-ST-segment elevation myocardial infarction (MI).* The program published a report that reviewed and rated diagnostic technologies for identifying patients with ACI, including AMI, in the ED. The recommendation was for continuing to review this area on a regular basis and expanding the review to include prognostic strategies as well as address non-ST-segment elevation MI.
- *Health care systems/community planning including all reimbursement systems (i.e., managed care, public, and private) and the uninsured.* The NHAAP Coordinating Committee recognized that the role of health care systems in the identification and treatment of individuals with symptoms and signs of acute coronary syndromes and the role of the community in ensuring access to timely and appropriate care for these patients are critical in the context of the rapidly changing health care environment.
- *New information technologies.* The NHAAP should take a more active role in the utilization of new information technologies such as the Internet and e-mail to improve dissemination of information and promote the goals of the program. Also, the NHAAP should explore telemedicine consultation, electronic decision support, and the development of data repositories to help ED physicians diagnose AMI.
- *Professional education*. The NHAAP should increase its efforts to educate all health care providers about the importance of early recognition and treatment of patients with a possible AMI, notably treatment with thrombolytic therapy, as well as the need to reduce barriers to care by targeting primary care physicians (family physicians, internists, and obstetricians and gynecologists); physicians "moonlighting" in emergency departments; and medical, nursing, and prehospital provider training programs.
- *High-risk patient education*. This was identified as a *critical* area of focus, especially until the results of research about the effectiveness and impact of public education and community inter-

vention to reduce patient delay are available from the REACT trial. The NHAAP has recently completed and submitted for publication a paper highlighting the importance of educating patients with known coronary heart disease about early recognition and response to future symptoms. The committee recommended that the program consider a broader definition of the high-risk patient at a future time.

- *Patients discharged from EDs, ruled out for AMI.* The NHAAP should outline an educational strategy for patients who come to the ED with chest pain but are ruled out for AMI. The ED should be considered as the entry point to the health care system, and the clinical manifestation of chest pain should be approached as an opportunity for primary care physicians in the community to capitalize on intervention and counseling of these individuals about cardiovascular disease risk factor reduction.
- *General public/bystander education*. Public education is the NHAAP's *ultimate* challenge. The NHAAP should continue to collect information on approaches to public education and focus on increasing knowledge and skills rather than changing behavior. The NHAAP should work more closely with organizations such as the American Heart Association and the American Red Cross as well as develop a synergistic relationship with the other national cardiovascular disease-related programs (i.e., the National High Blood Pressure Education Program and the National Cholesterol Education Program).

Organizational Structure and Processes

The Coordinating Committee presented a number of recommendations concerning the organizational structure and processes of the NHAAP. The following recommendations that will be implemented by the NHAAP are representative of the key constructive suggestions aimed at optimizing the committee's efficiency and involving the members.

- Keep the NHAAP Coordinating Committee membership broad based and multidisciplinary.
- Involve all Coordinating Committee members in a committee or subcommittee based on their preference through an open enrollment process.
- Increase the scope of the Executive Committee to include prioritizing the NHAAP's efforts, monitoring program progress and impact, developing meeting agendas, and reviewing applications and suggestions for additional Coordinating Committee member organizations. The composition of the Executive Committee will include the chairs of the NHAAP subcommittees and representatives from the American Association of Family Physicians and the National Medical Association.
- Retain the Science Base Subcommittee and the Data Advisory Group as standing committees.
- Create the Health Systems Subcommittee to replace and expand the role of the Access to Care Subcommittee, encompassing a whole systems approach.
- Create an Education Subcommittee to initially focus on health professionals and high-risk patients and eventually become involved with public education.
- Alternate small-group and large-group sessions at Coordinating Committee meetings on the basis of the work to be accomplished.

- Increase group meetings, particularly via conference calls and e-mail, to facilitate communication between meetings.
- Develop an orientation/mentorship program for new Coordinating Committee members.
- Distribute materials for conference calls and meetings well in advance to ensure adequate time for review prior to the meetings.

Member Organizations' Roles/Responsibilities

Dr. Claude Lenfant, director of the NHLBI and chair of the NHAAP, pointed out that the NHAAP Coordinating Committee is only as strong as the relationship of the individual representative with his or her own organization and that the NHAAP depends on the representatives to carry the program's initiatives back to their respective organizations and stimulate relevant activities within these organizations.

At the anniversary retreat, Coordinating Committee members reviewed their relationship with their organizations and considered specific ways to make their representation more effective during the next 5 years. NHAAP staff members pledged their support to facilitate more effective communications between the member representative and the organization.

Publications

The following NHAAP publications produced in the first 5 years of the program can be ordered from the NHLBI Information Center by phone at 301-251-1222, fax at 301-251-1223, or writing the NHLBI Information Center, P.O. Box 30105, Bethesda, MD 20824-0105. Publications are also available through the Internet on the NHLBI Gopher (fido.nhlbi.nih.gov) and the World Wide Web (http://www.nhlbi.nih.gov/nhlbi/nhlbi.htm).

National Heart Attack Alert Program Coordinating Committee, 60 Minutes to Treatment Working Group. Emergency department: rapid identification and treatment of patients with acute myocardial infarction. *Ann Emerg Med* February 1994;23:311-329.

National Heart Attack Alert Program Coordinating Committee, Access to Care Subcommittee. Staffing and equipping emergency medical services systems: rapid identification and treatment of acute. *Am J Emerg Med* 1995;13:58-66.

National Heart Attack Alert Program Coordinating Committee, Access to Care Subcommittee. Emergency medical dispatching: rapid identification and treatment of acute myocardial infarction *Am J Emerg Med* 1995;13:67-73.

National Heart Attack Alert Program Coordinating Committee, Access to Care Subcommittee. 9-1-1: rapid identification and treatment of acute myocardial infarction. *Am J Emerg Med* 1995;13:188-195.

Dracup K, Moser DK, Eisenberg M, Meischke H, Alonzo AA, Braslow A, et al, for the National Heart Attack Alert Program. Causes of delay in seeking treatment for heart attack symptoms. *Soc Sci Med* 1994;40:379-392.

Dracup K, Atkins JM, Bennett MS, Braslow A, Clark LT, Alonzo AA, et al, Working Group on Educational Strategies To Prevent Prehospital Delay in Patients at High Risk for Acute Myocardial Infarction. The physician's role in minimizing prehospital delay in patients at high risk for acute myocardial infarction: recommendations from the National Heart Attack Alert Program. *Ann Intern Med* 1997;126:645-651

Selker HP, Zalenski RJ, Antman EM, Aufderheide TP, Bernard SA, Bonow RO, et al. An evaluation of technologies for identifying acute cardiac ischemia in the emergency department: executive summary of a National Heart Attack Alert Program working group report. *Ann Emerg Med* January 1997;29:1-12.

Selker HP, Zalenski RJ, Antman EM, Aufderheide TP, Bernard SA, Bonow RO, et al. An evaluation of technologies for identifying acute cardiac ischemia in the emergency department: a report from a National Heart Attack Alert Program working group report. *Ann Emerg Med* January 1997;29:13-87.